

MEDICAL HISTORY

NAME _____ DATE _____

DATE OF YOUR LAST PHYSICAL EXAMINATION _____ WEIGHT _____ HEIGHT _____

ALL PREVIOUS SURGERY (INCLUDING COSMETIC SURGERY)

	TYPE	DATE	COMPLICATIONS OR DIFFICULTIES
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

MEDICAL PROBLEMS OR CONDITION NOW UNDER TREATMENT BY A PHYSICIAN

EXPLAIN: _____

ADMISSIONS TO HOSPITAL

	REASON	DATE	COMPLICATIONS OR DIFFICULTIES
1.	_____	_____	_____
2.	_____	_____	_____

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

	TYPE	DOSAGE/AMOUNT IF KNOWN	TAKE HOW OFTEN
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

CONSUMPTION OF THE FOLLOWING

ASPIRIN: DAILY _____ WEEKLY _____ ALCOHOL: DAILY _____ WEEKLY _____ TOBACCO: DAILY _____ WEEKLY _____

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY (CUTS, TOOTH EXTRACTIONS, PREGNANCY)? YES NO EXPLAIN: _____

DO YOU HAVE A FAMILY HISTORY OF BLEEDING PROBLEMS? EXPLAIN: _____

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN: _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO ARE YOU PREGNANT? YES NO

HAVE YOU EVER BEEN EXPOSED TO (PLEASE CIRCLE YES OR NO)

YES NO	INTRAVENOUS DRUGS	YES NO	TB	YES NO	HEPATITIS	YES NO	BLOOD TRANSFUSION
YES NO	INFECTIOUS DISEASES	YES NO	AIDS	YES NO	HIV	YES NO	LIVER TRANSPLANT

IF YES TO ANY EXPLAIN: _____

HISTORY OF EPILEPSY OR MENTAL ILLNESS

EXPLAIN: _____

MEDICAL HISTORY

CHILDHOOD MEDICAL HISTORY (PLEASE CIRCLE YES, NO OR UNCERTAIN)

HAD ALL KNOWN "BABY SHOTS"?	YES	NO	UNCERTAIN
HAD POLIO IMMUNIZATION?	YES	NO	UNCERTAIN
HAD RHEUMATIC FEVER?	YES	NO	UNCERTAIN

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER _____

SISTER _____

FATHER _____

BROTHER _____

OTHER RELATIVE: _____

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

NO _____ HEAD, IF YES EXPLAIN _____

NO _____ EYES, IF YES EXPLAIN _____

NO _____ EARS, IF YES EXPLAIN _____

NO _____ THYROID, IF YES EXPLAIN _____

NO _____ LUNGS, IF YES EXPLAIN _____

NO _____ HEART, IF YES EXPLAIN _____

NO _____ BLOOD PRESSURE OF VESSELS, IF YES EXPLAIN _____

NO _____ DIGESTIVE SYSTEMS, IF YES EXPLAIN _____

NO _____ LIVER, IF YES EXPLAIN _____

NO _____ MUSCLES-BONES, IF YES EXPLAIN _____

NO _____ REPRODUCTIVE ORGANS, IF YES EXPLAIN _____

NO _____ KIDNEY'S-BLADDERHEAD, IF YES EXPLAIN _____

NO _____ UNSIGHTLY SCARS, IF YES EXPLAIN _____

NO _____ OTHER, IF YES EXPLAIN _____

NO _____ DISEASE AFFECTING IMMUNE SYSTEM, IF YES EXPLAIN _____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATION(S)?

PLEASE LIST

Patient Signature

Date